Nebraska Department of Health and Human Services

Access Monitoring Review Plan

October 1, 2016

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1. STATEMENT OF PURPOSE

On November 2, 2015, the Centers for Medicare and Medicaid (CMS) issued its final rule with comment period for CMS-2328-FC (Access to Care Rule). This final rule requires that each state submit an initial access monitoring review plan (AMRP) by October 1, 2016, documenting the state's efforts to ensure adequate access to covered services for Medicaid-eligible individuals served through the state's fee-for-service (FFS) delivery system.

The State of Nebraska has developed this AMRP in accordance with the requirements detailed in 42 CFR §447.203, §447.204, and §447.205 as amended and based on additional technical assistance provided by CMS. This AMRP provides a description of the current Medicaid program, details changes underway to the Medicaid delivery system, documents the State's efforts to measure and monitor access to care, and describes the mechanisms the State of Nebraska will employ to assess how changes in FFS provider reimbursement rates will impact access to care for eligible individuals.

2. MEDICAID OVERVIEW

The State of Nebraska's Medicaid program is administered by the Department of Health and Human Services' (DHHS) Division of Medicaid and Long-Term Care (MLTC). Nebraska Medicaid provides health care services to eligible elderly and disabled individuals and eligible low-income pregnant women, children, and parents.

Approximately 230,000 Nebraskans receive medical coverage through Medicaid and the Children's Health Insurance Program (CHIP). For State Fiscal Year (SFY) 2015[1], Medicaid and CHIP expenditures totaled approximately $1.8 billion.

2.1 MEDICAID AND CHIP ELIGIBLE POPULATIONS

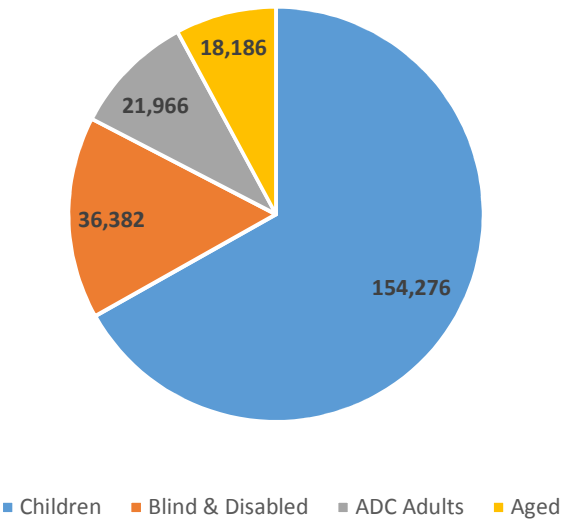
Nebraska Medicaid provides coverage for individuals in the following eligibility categories:

- Children,
- Former Foster Care Youth,
- Aged, Blind & Disabled (ABD),
- Pregnant Women, and
- Parent/Caretaker Relatives.

Eligibility factors vary by group and include income, resources, and employment status. Rules for Nebraska Medicaid eligibility are detailed in Nebraska Administrative Code (NAC) 477.

[1] The state fiscal year runs from July 1st to June 30th.

Figure 1: Eligible Populations SFY 2015



2.2 MEDICAID AND CHIP EXPENDITURES

Figure 2 shows the five largest categories of Medicaid and CHIP expenditures to vendors by vendor type. A comprehensive listing of expenditure categories is available in Attachment 1 – Nebraska Medicaid Reform Annual Report for State Fiscal Year 2015. Figure 3 shows SFY 2015 expenditures to vendors by eligibility category.

Figure 2: Expenditures by Vendor Type SFY 2015

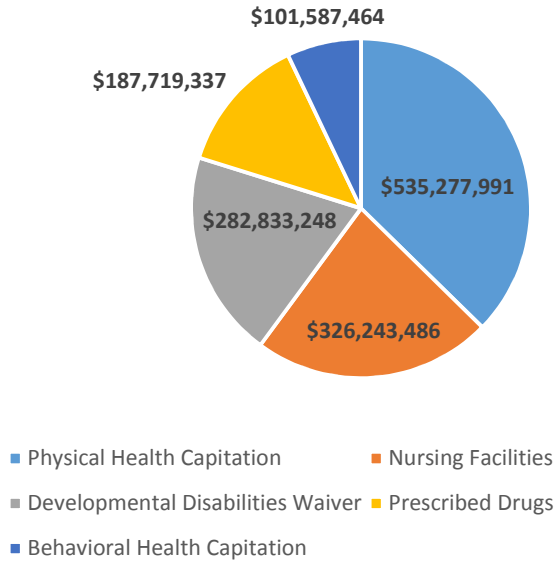
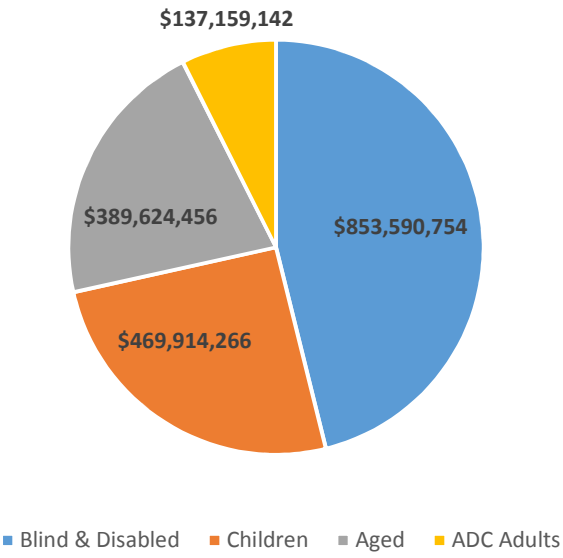


Figure 3: Expenditures by Eligibilty Category SFY 2015



2.3 MEDICAID DELIVERY SYSTEMS

2.3.1 CURRENT MANAGED CARE PROGRAM

Most Medicaid eligible individuals in Nebraska receive their health benefits through the managed care delivery system. The Nebraska Medicaid Managed Care Program (NMMCP), first implemented in July 1995, now includes approximately 189,000 individuals enrolled in physical health managed care and approximately 229,000 individuals enrolled in behavioral health managed care. Those individuals who are enrolled in behavioral health managed care, but not physical health managed care, receive their physical health services from Nebraska Medicaid under the FFS reimbursement model.

NMMCP is authorized under section 1932 of the Social Security Act, which permits a state to operate a managed care program through its Medicaid State Plan. Additionally, Nebraska operates a 1915(b) waiver requiring special needs children and Native Americans to participate in the managed care program. The 1915(b) waiver permits Nebraska Medicaid to operate the behavioral health managed care program.

NMMCP currently includes:

- Physical health managed care provided through risk-comprehensive contracts that are fully-capitated and require the contracted entity to be a managed care organization (MCO) or health insuring organization. “Comprehensive” means that the contracted entity is at financial risk to provide all the services in the core benefits package. The physical health managed care program was expanded from three (3) counties to all ninety-three (93) counties on July 1, 2012. The State of Nebraska currently contracts

with two MCO networks serving ten counties in the East-Central region of the state and two MCO networks serving the remaining eighty-three (83) counties.

- Behavioral health managed care provided through one, statewide prepaid inpatient health plan (PIHP) which is not comprehensive, but is fully-capitated. The current behavioral health managed care program was implemented on September 1, 2013.

2.3.2 IMPLEMENTATION OF HERITAGE HEALTH

On January 1, 2017, MLTC will launch the Heritage Health managed care program. The implementation of Heritage Health brings several changes to the State's managed care program including:

- Integration of physical and behavioral health managed care through three (3) MCO contracts operating in all ninety-three (93) counties in the state of Nebraska.
- Inclusion of pharmacy services in the core benefit package and the MCO capitation rate.
- Inclusion of the Aged, Blind and Disabled populations who are dually eligible for Medicaid and Medicare, in a home and community-based services (HCBS) waiver program, or living in an institution, for integrated physical health, behavioral health, and pharmacy services.

While individuals receiving long-term services and supports (LTSS) will be included in Heritage Health for their medical, behavioral health, and pharmacy services, their LTSS services, as detailed in Section 2.3.4, will continue to be administered through the legacy FFS delivery system.

With the implementation of Heritage Health, the only populations remaining in the legacy FFS program will be:

- Aliens who are eligible for Medicaid for an emergency condition only.
- Beneficiaries who have excess income or who are required to pay a premium, except those who are continuously eligible due to a share of cost obligation to a nursing facility or for HCBS Waiver services.
- Beneficiaries who have received a disenrollment or waiver of enrollment.
- Participants in the Program for All-Inclusive Care for the Elderly
- Beneficiaries with Medicare coverage where Medicaid only pays co-insurance and deductibles.
- Inmates of public institutions.

These remaining populations within the FFS program will constitute less than 2% of the Medicaid eligible population in Nebraska.

2.3.3 TRANSITION TO MANAGED DENTAL BENEFITS PROGRAM

MLTC is currently developing a request for proposals (RFP) to procure a dental benefits manager (DBM) that will administer the State's new Medicaid managed care dental

program. The DBM will be structured as a single, statewide, fully-capitated, prepaid ambulatory health plan (PAHP). MLTC is planning the release of the DBM RFP in late summer 2016 and anticipates that implementation of the program to start on July 1, 2017.

2.3.4 FEE-FOR-SERVICE PROGRAM

The following Medicaid services will continue to be administered through the FFS delivery system after the implementation of Heritage Health and the launch of the DBM:

- LTSS such as nursing facility custodial care, services provided in intermediate care facilities for persons with developmental disabilities (ICF/DD), HCBS waiver services, and personal assistance service (PAS).
- School-based services for Medicaid eligible children that provide speech therapy, occupational therapy, physical therapy, and personal assistance care based on the child's special education plan.
- Non-emergency medical transportation services which provide transportation for eligible individuals for medically-related appointments.

2.3.5 LONG-TERM CARE REDESIGN

MLTC has contracted with a consultant to develop recommendations for MLTC's future administration of long-term care services. The consultant is engaging stakeholders throughout the redesign process as it evaluates the needs of LTSS recipients, provider concerns, and the current LTSS program structure. A draft plan for long-term care redesign is scheduled to be released for stakeholder review and input in January 2017. MLTC anticipates the final redesign plan to be completed in May 2017.

Information about the long-term care redesign project is available at: http://dhhs.ne.gov/medicaid/Pages/medicaid_LTC.aspx

3. MEDICAID ACCESS TO CARE PROFILE

3.1 GENERAL ACCESS CHALLENGES

In Nebraska, challenges to accessing care for Medicaid eligible individuals are primarily driven by geographic factors. Nebraska ranks 45th in population density[2] with 23.8 persons per square mile. As illustrated in Attachment 2 – "Nebraska Counties Classified by Urban, Rural or Frontier Status", of the State's ninety-three (93) counties, forty-eight (48) are considered "rural" and thirty-one (31) are considered "frontier" for purposes of establishing managed care access standards.

The geographic challenges impeding access to care for Medicaid-eligible individuals are similar to challenges facing the general Nebraska patient population. Attachment 3 – "State-Designated Shortage Area – Medical and Mental Health", illustrates the shortage of practitioners by

[2] U.S. Census Bureau: 2010 Census

specialty type predominately in rural areas of the state. Access to behavioral health services in all areas other than the state's two largest metropolitan areas is limited as demonstrated in Attachment 4 – "State-Designated Shortage Areas Psychiatry & Mental Health".

3.2 ADDRESSING ACCESS THROUGH MANAGED CARE

MLTC views the ongoing transition to managed care as the State's primary mechanism for addressing Medicaid delivery challenges including ensuring adequate access to care for beneficiaries.

- Challenges in accessing behavioral health services, particularly in rural areas, were an important factor in the State's decision to launch its initial behavioral health managed care program in 2013. Improving access to behavioral health services is also an important element guiding the State's development of the Heritage Health integrated managed care program.
- Maintaining adequate access to primary care dentists and expanding access to dental specialists are key considerations in the decision to transition the State's FFS dental program to the MMDBP.

Managed care entities provide national-level expertise in the development of provider networks, along with more modern claims management systems and scalable prior authorization services for Medicaid providers. This expertise and infrastructure are important factors in encouraging and maintaining provider participation in the Medicaid program.

3.3 FEE-FOR-SERVICE POPULATION CHARACTERISTICS

Medicaid-eligibility for the populations remaining in the FFS delivery system is particularly volatile, which when combined with the small size of these populations, inhibits MLTC's ability to provide more exact projections for population size, composition, location, and service utilization. The estimates included in this section represent the State's best approximations based on analysis of those populations as they exist as of the submission date of this plan.

With the implementation of Heritage Health, MLTC projects that the Medicaid eligible populations remaining in the FFS delivery system, listed in Section 2.3.2, will constitute less than 2% of the overall Medicaid population. MLTC estimates that over the course of a calendar year, approximately 2,500 unique individuals will become Medicaid eligible within those remaining FFS population categories. Of those 2,500 eligible individuals, MLTC anticipates that approximately 50% are likely to be beneficiaries who have a share of cost obligation that must be met before that individual becomes Medicaid eligible.

4. MEASURING ACCESS TO CARE

4.1 ACCESS MEASUREMENT METHODOLOGY

MLTC utilized a ZIP Code Tabulation Area (ZCTA) analysis to evaluate access to care for the remaining FFS populations listed in Section 2.3.2. The analysis included Medicaid-enrolled providers for the required service categories listed in §§447.203(b)(5)(ii)(A-D). The geographic access standards used for the ZCTA analysis were based on the standards identified for the Heritage Health managed care program and included as Attachment 5 – "Heritage Health Access Standards".

4.2 ACCESS ASSESSMENT

MLTC's ZCTA-based analysis projects the following estimates of access for the access to care final rule's required service categories:

- 100% of the FFS population would have access to a primary care provider within MLTC standards.
- 100% of the FFS population would have access to some specialty services within MLTC standards.[3]
- Less than 1% of the FFS population may potentially lack access to a pre- and post-natal provider based on MLTC access standards.
- Less than 1% of the FFS population may potentially lack access to behavioral health services based on MLTC access standards.

4.2.1 HOME HEALTH SERVICES

In Nebraska, Home Health services for FFS populations are delivered primarily by Home Health agencies and private duty nurses. MLTC has not previously established geographic or timely services access standards for Home Health. The availability of these services are determined by the locations each provider chooses to serve and each providers' client capacity.

5. REIMBURSEMENT RATE ANALYSIS

5.1 RATE COMPARISON METHODOLOGY

MLTC chose services for its reimbursement rate comparison based on the list of services currently included in the State's enhanced primary care payments program (EPC). On December 31, 2014, the federal government ended funding for enhanced primary care reimbursement for certain primary care providers as required by final rule CMS-2370-F. The State of Nebraska

[3] The availability of specific specialty services will vary based on the location of the Medicaid FFS-eligible individual. As the Access to Care Final Rule did not include a list of specialists that states are required to analyze, MLTC included those Medicaid-enrolled Doctors of Medicine and Doctors of Osteopathic Medicine in this category who did not fall within the four other required service type categories.

chose to continue providing enhanced payments to qualifying providers for certain primary care services. These enhanced payments remain in effect as of the submission of this AMRP.

5.2 RATE COMPARISON

Attachment 6 – "Reimbursement Rate Comparison" details reimbursement rates for services included in the State's EPC payments program and non-EPC Nebraska Medicaid reimbursement rates for the same services included in the EPC list. The EPC and non-EPC rate lists are compared to the following rate schedules:

- Medicare reimbursement rates
- Iowa Medicaid reimbursement rates
- Colorado Medicaid reimbursement rates
- Texas Medicaid reimbursement rates

Attachment 6 – "Reimbursement Rate Comparison" includes a category code denoting which of the required services categories are impacted by each rate. A key for the category code is included in the attachment.

6. STAKEHOLDER OUTREACH

MLTC addresses the various stakeholder input requirements in the access to care final rule throughout this section. Section 6.1 summarizes the prior stakeholder input that guided the development of the AMRP. Section 6.2 details the AMRP public comment period as required by the amended §447.203(b).

6.1 INCORPORATING STAKEHOLDER INPUT

Prior to the release of the access to care final rule, MLTC did not employ a formal tracking process for capturing stakeholder access concerns for services provided through the FFS program. Notwithstanding the absence of a formal process, MLTC has received feedback through the Division's regular engagement with providers, recipients, advocacy organizations, and other stakeholders that includes concerns about the lack of access to certain covered services.

For purposes of analyzing access to services and reimbursement rates as required by the access to care final rule, MLTC determined that the service type categories included in §§447.203(b)(5)(ii)(A-E) sufficiently encompass those services that stakeholders have identified as areas where accessing care may have proven challenging in the past.

6.2 AMRP STAKEHOLDER FEEDBACK

On August 16, 2016, MLTC posted the draft AMRP for public review and comment on the State's Medicaid website at http://dhhs.ne.gov/medicaid/Pages/MedicaidPublicNotices.aspx

The State also issued a public notice alerting stakeholders and the general public to the AMRP release and the opportunity to comment on the draft. MLTC created a dedicated email address DHHS.AMRPComments@nebraska.gov for the submission of comments.

PLACEHOLDER FOR SUMMARY OF PUBLIC COMMENTS

PLACEHOLDER FOR EXPLANATION OF PUBLIC COMMENT INCORPORATION

7. ACCESS TO CARE MONITORING

7.1 INFORMATION REQUIREMENTS

As required by §447.204, prior to Nebraska Medicaid submitting a state plan amendment that proposes to reduce or restructure Medicaid service payment rates for services included in §§447.203(b)(5)(ii)(A-E), the Agency will consider the following:

- The data collected, and the analysis performed, under §447.203.
- Input from beneficiaries, providers and other affected stakeholders on beneficiary access to the affected services and the impact that the proposed rate change will have, if any, on continued service access.

7.2 WEBSITE REQUIREMENTS

As noted in Section 6.2, Nebraska Medicaid created a dedicated page for public review and comment on the State's proposed access monitoring review plan. That webpage or a similar dedicated page will be maintained and updated in accordance with the requirements in §447.205 which include:

- The site be clearly titled and easily reached from a hyperlink included on Web sites that provide general information to beneficiaries and providers, and included on the State specific page on the Federal Medicaid Web site.
- The site is updated for bulletins on a regular and known basis and the public notice is issued as part of the regular update.
- The site complies with national standards to ensure access to individuals with disabilities.
- Includes protections to ensure that the content of the issued notice is not modified after the initial publication and is maintained on the Web site for no less than a 3-year period.